Wisconsin Department of Regulation & Licensing

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DENTISTRY EXAMINING BOARD

LOCAL ANESTHESIA CERTIFICATE OF COMPLETION

THIS FORM MUST BE COMPLETED BY YOUR DENTAL OR DENTAL HYGIENE SCHOOL AND RETURNED TO THE DENTISTRY EXAMINING BOARD AT THE ABOVE ADDRESS

APPLICANT - Please complete this section.

NAME (First, Middle, Maiden, Last) _____	Social Security Number* ____ ____ ____ - ____ ____ - ____ ____ ____ ____
ADDRESS (City, State, Zip) _____	Date the Course Completed ____ ____/ ____ ____/ ____ ____ ____ ____

CERTIFYING SCHOOL – Please complete this section.

NAME OF INSTITUTION _____	LOCATION OF INSTITUTION _____
NAME OF COURSE _____	DATE COURSE COMPLETED _____
☐ Inferior alveolar injection completed on a non-classmate patient as part of course work. (If "yes," check box)	

The completion of this form by the instructor certifies that the course completed is in compliance with DE 7 of Wisconsin Administrative Code.

_____
Signature of Instructor

SCHOOL SEAL

_____
Date

* For use in the school locating your records.

** **DO NOT COMPLETE THIS FORM UNTIL THE INDIVIDUAL NAMED ABOVE HAS COMPLETED THIS COURSE**. Anticipated dates of completion will not be accepted.

#2457 (Rev. 2/03)
Ch. 447, Stats.